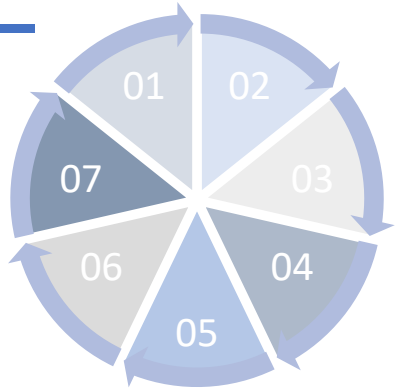
BCSSP – 7 Minute Briefing

Safeguarding Adult Review (SAR) – 'Angus'

01. Rationale for a Safeguarding Adult Review (SAR): The BCSSP has a legal duty to review any case it is made aware of where an adult with care and support needs has died, or sustained serious injury, as a result of abuse or neglect (including self-neglect); and there is reasonable cause for concern that partners did not work together effectively to safeguard the individual.

The purpose is to identify lessons learnt so that these can be applied in future safeguarding work. The full report can be found on the BCSSP website: https://bcssp.bathnes.gov.uk/node/112

02. What happened in the case of Angus? Angus was a divorced man with two sons, with whom he had little contact. For a number of years, Angus was supported by his niece, but this support declined due to his niece's own commitments. He had a history of chronic alcohol abuse and presented with signs of self-neglect. He had a diagnosed cognitive impairment and had been resident in a care home under a Deprivation of Liberty Safeguard (DoLS) in 2019. Angus returned to living in the community with a support package but a pattern of self-neglect, alcohol abuse and regular falls in his home followed. Angus developed an infected leg and pressure sores. Angus died as a hospital inpatient, aged 72 years.



03. Learning Point 1: Returning to the Community. Angus had been supported in residential care under a DoLS authorisation. He wished to return to more independent living and have his own tenancy in the community. He was deemed not to have capacity to participate in discharge planning and was represented by an IMCA. It was decided that it was in his best interests that he lived in the community, with a support package and that this was the least restrictive option.

Angus suffered a fall in his home and fractured his hip, this was the same injury that previously led to residential care under a DoLS authorisation. Where a decision is made in a person's best interests the decision should be reviewed in light of a change of circumstances and an increase in risk.

04. Learning Point 2: Self-neglect & Safeguarding Enquiry. Where there is identification of self-neglect, particularly in cases where there is a history of this, professionals should make early use of the B&NES self-Neglect Best Practice Guidance. Where a s42(2) enquiry is opened it should not be closed prematurely on the basis that other measures are in place until it is established that they are effective, and the enquiry should fully consider the history of the case. The person should be involved in the enquiry or where there is a substantial difficulty, a person known to them, or family member involved. Where this is not possible consideration should be given to using an independent advocate.

05. Learning Point 3: Mental Capacity. Mental Capacity and Best Interest decisions can be complex, it is difficult for front line, first attending staff to be fully equipped to deal with all eventualities and agencies need to be able assist them to allow decision making to be as straightforward as is possible. Where cases allow, it would assist to have an agreed process and protocol signed up to by all agencies who may perform a function in relation to the care and support which would allow for pre-planning and discussion regarding how desired outcomes can be achieved.

06. Learning Point 4: Best Interest Decisions. Where there are cases of mental capacity involving best interest decisions regarding life sustaining treatment, which involve more than one agency, there should be pre-planning to allow all agencies to understand their role, understand the legislation and what is considered appropriate and proportionate. All agencies when making best interest decisions for persons who lack mental capacity should ensure that they consult others close to the person who lacks capacity and where this is not possible, that consideration is given to the involvement of an independent advocate.

07. Learning Point 5: Escalation. There was an impasse on the issue of conveying a person to hospital who lacked mental capacity. There was a MARM meeting which discussed some of the issues, but the issues were not properly discussed and resolved although a number of the involved agencies were present. This was a missed opportunity to resolve the issue. The partnership protocol for resolving professional differences[1] was not considered or used. This would have allowed professionals to work through the different stages to reach a resolution.